



Part 3:  
*Scaffolding of practice towards identity,  
advocacy and communities of support*

*by Courtney Olinger*



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### *Abstract*

This is the third article in a three-part series exploring narrative practices and autism. The concepts in these papers can be helpful for work with a wide presentation of neurodivergence. In this paper, identity constructions and ways to consider the role of diagnostic conceptualisations are a central focus. This is particularly relevant when considering advocacy and the development of communities of support. I hope to represent the re-authoring of autism that can occur with the deconstruction of limiting ideas around autism and the reconstruction of a preferred label.

***Key words: autism; Asperger's; neurodiversity; sensory processing; neurodevelopment; narrative practice; telehealth; identity; self-advocacy; communities of support***

This is the third part of a three-part series exploring narrative practices with autism. In Part 1, I shared some of the philosophical tenets of my work and potential strategies for making therapy more accessible. In Part 2, I attempted to highlight the voices of autistic individuals and family members as a means to expand on typical clinical understandings of autism. As with my guiding theory and many of the practices I use to support engagement, many of the following ideas and practices can be used with all sorts of clients and concerns. In this paper, I focus on and provide examples of work with autistic clients because these were the clients I learnt the most with, and with whom I used the most creativity as I worked alongside them.

## Identity

A central focus of the work I engage in with my clients is that of supporting preferred identity developments. I am curious about constructions and performances of identity (Tilsen, 2007), particularly those associated with the notion of normality (Hutton & Knapp, 2008). In my work, I listen for threads of identity development that are problem-saturated or unhelpful for a person or group of people. In response, I ask questions like:

- What messages does a person get from society about how they *should* or *should not* be or what is *normal* or *not normal*?
- What is the history of these ideas? Where do these ideas come from? What purpose do these ideas serve? Who supports such ideas and why? How are these ideas passed on to others?
- Are there other ideas that you prefer or that you would like to be more supported by society? How might this change things for the better? Who might support these ideas? Do these ideas speak to values, something that is important to you or preferences you hold?
- What might be possible – for you, in your relationships or for others – if you were able to live more by these preferences and values?

I often show videos that depict alternate ideas and explore whether these ideas resonate in any way. With various telehealth platforms, these can be presented through screen share or presentation mode. I encourage clients who struggle with expressive language or who prefer other forms of expression to bring in music, art, poetry or quotations that speak to their experience so we can explore and look for these preferences and values.

I gather what I have heard and seen and list them under 'preferences', 'values', 'challenges and concerns' (the social discourses and relational problems that get in the way), and 'supports'. This list becomes a working document that the client and I can edit, revise, rework, add to and take away from as they become clearer about these aspects of identity development. For an autistic person, the discourses that come up in these conversations (e.g. gender, ability, race, normality, worth) are often no different from discourses that come up with a so-called neurotypical client; however, the experience of these discourses is often quite different.

## Addressing a label

When attending to identity, I am also keenly aware that diagnostic language and diagnosing itself often collude with problematic or limiting identity descriptions. As a narrative therapist, I am sceptical of the constructs that reside in the Diagnostic and Statistical Manual (DSM), particularly because a look at the history of the DSM shows diagnoses to be constructs that are ever changing and often determined by what is relevant to those in power at a particular time. In 2013, the DSM went from its fourth edition (American Psychiatric Association, 1994) to fifth edition (American Psychiatric Association, 2013). With this, there was a change in the way that those in academic and clinical settings talked about and looked at Autism Spectrum Disorder, which was no longer presented as a set of three separate labels. While a debate on the differences between DSM-IV and DSM-5 is outside of the scope of this article, what that time yielded was a greater awareness that diagnosis is fallible, constructed and ever changing. I spent many months in anticipation of that change speaking with parents and autistic adults about their concerns about the changing of a label and their preferences. I also first read about the neurodiversity movement and the movement's reclamation of the identity of 'autistic' (Armstrong, 2015; Charlton, 1998; Sinclair, 1993; Solomon, 2008). What I learnt is that, just like any other identity, we risk making harmful assumptions if we do not take time to explore different labels that are being used, ask questions about preferences and what is informing these, and acknowledge and support the ways that a person prefers to be identified, even if that continues to change.<sup>1</sup>

I am invested in continuously expanding my and others' understandings of autism as a way to tackle the limitations that exist if we view autism through a lens

of dysfunction or deficit, shifting away from the view of deficit to one of possibility and agency. Agency includes a call to responsible action and to inhabiting one's life as an active participant (Avdi, 2005; Ewing & Allen, 2008; McNiff & Whitehead, 2006; White, 2007; White & Epston, 1990; White & Morgan, 2006). In order to support this possibility, the person must be central to their services, supports and life happenings, which best occurs when they have information and a voice.

Over the years, I have shifted my ideas about when to share a diagnostic label, thanks to many of the autistic adults I have worked with (some of whom prefer 'adult with autism'). Resoundingly, adults I have spoken to who were told about their diagnosis later in their life have said they wondered whether this information had been hidden from them because it was something to be ashamed of. They often spoke to a sort of internalisation that something must have been wrong with them for it to have been kept from them for so long. My experience has been that an individual (typically an adult) often expresses relief in knowing that there is a name for what they have been experiencing. Some speak about feeling less alone in their struggles and go on to find communities of support.

Some (typically children and adolescents) would rather distance themselves from diagnostic terms. In all cases, I consider the ways agency can help the person to navigate a label or identity construction that others will continue to impose on them. Rather than shying away from diagnosis or diagnostic language, I have embraced transparency in relation to the systems that I work in, and I create space to explore, consider and understand each diagnosis. I openly acknowledge the discourses that promote limitations and ask questions about the ways the individual may have experienced abuses of power. I seek to support experience-near descriptions in which the diagnostic term is situated by context and experience. I seek to create space for the person to name their preferences, and support them in navigating within a system in which others may use less or non-preferred terms.

### ***Considerations of ways in which a diagnosis or label may be helpful***

Before engaging with anyone in relation to diagnosis, I spend time explaining the different types of assessment, what sort of access or support an assessment will yield, alternatives to assessment, and potential risks and benefits of assessment. There are many reasons that a diagnosis or label may be used. In my experience, the most common reasons

that an autism label is requested are 'looking for answers', needing a label for access to supports and services (e.g. In the United States, a DSM diagnosis is a requirement for government-funded and insurance-funded support and for some educational services), 'validation', and sometimes people even see a diagnosis as a way to remove stigma (an acknowledgment that there is a reason they face certain struggles). Their reasons do not dictate what diagnosis is given, but rather inform me about how much support is needed to deconstruct discourses that are unhelpful.

### ***A story of navigating a label and systems***

Peter was 16 years old when I met him. At our first session, I was waiting at our front desk when his mother came in and said he would not get out of the car. I walked out to the car with her. Peter sat in the front passenger seat with his head hanging out the window. I introduced myself and asked if he would be willing to come in to see my office. I told him he did not need to talk if he did not want to. He grunted, pushed the car door open and slid out of the car. I could tell that he did not want to be there and that just walking required a lot of energy.

When she made the appointment, Peter's mother had shared that Peter had not been to school in over six weeks, and that he would rarely leave the house or get out of bed. She told me that Peter's father had a diagnosis of Asperger's and that a psychiatrist had also recently diagnosed Peter. She shared that Peter was quite bright and capable of carrying a conversation, but that he had struggled socially, really not been interested in others or aware of others in early childhood, but had a sudden shift in awareness around puberty. She also shared that he had struggled with a subject in which he was required to write and perform speeches in front of the class. He had fallen ill around winter break, causing him to be disconnected from others and fall behind in school. Peter had recovered from the illness but had not recovered from the isolation, fear of speaking and overwhelm of falling behind. He had fallen into a deep depressive state.

In the first five sessions, Peter did not talk to me much. I mostly talked to myself and sometimes I had his mother come in so I could interview her, in Peter's presence, about what she appreciated about him and what she understood as his concerns and dislikes. Peter would periodically grunt and gradually his grunts became more communicative. In sessions four and five he mumbled a bit more with 'uh-huh' and 'maybe'. On the sixth session, I brought in my DSM (then the DSM-

IV) and said, 'Your mother has told me that your father has a diagnosis of Asperger's and you do not think you are anything like your father so I am wondering if we can look at what Asperger's means and see what is like you and what is not?' He perked up and looked at the thick book in my hands, asking what it was that I was holding. I explained that the DSM was a book that doctors, therapists and psychiatrists often used to try to find a name for the concerns that a person was describing. I shared that it was supposed to be a book that helped doctors, therapists and psychiatrists identify ways to help or provide support and that sometimes it was helpful and sometimes it was not. I asked if he wanted to take a look and he indicated he did, but with a groan and a verbalisation that indicated he was both intrigued and also felt this was stupid.

We went through the criteria for Asperger's Syndrome line by line. I asked if he understood each line and had him explain to me what he understood. If he did not appear to understand, I broke it down more and gave some examples. Then I asked if he thought that fit for him or not. If he said it did, I would ask him to share an example or a story of how it fit. If he said it did not fit, I moved on. Peter spoke freely, clearly indicating when something did not fit. He was much more inclined to say what did not fit, and I noticed that for many other answers he would groan and say 'maybe' or 'I don't know'. This seemed to me an indication that perhaps something was resonating, and on those items, I would break the words down a bit more and ask more questions. He began sharing some stories of struggles and challenges that he had faced.

As he spoke, I noted on a whiteboard the points he indicated as a fit. When we were done, I said, 'So Peter, these things on the board are all examples of experiences that doctors, therapists and psychiatrists might call Asperger's so they can better understand and support you, but I have learnt that you do not like the term Asperger's'. Peter vehemently voiced his dislike. 'So what would you prefer to call it?' I asked. 'Unique person' he replied after some thought. 'Ah, unique person. Does that fit better for you?' I asked. Peter expressed that it did and that he believed everyone was unique. I agreed with this and then added, 'Now that you have a better understanding of why someone might call it Asperger's, are you okay with doctors, teachers, psychiatrists and therapists thinking of this as Asperger's if that helps them better understand or get you more support and services?' Peter thought about it and said he could understand but did not want it used around him. He then told me that every time he went to the psychiatrist, she said 'Asperger's this

Asperger's that' and it really bothered him. I asked if he could speak up and tell her that he preferred 'unique person'. He immediately shook his head and said 'no, you don't talk back to your elder'. 'I see. Well, do you think there's someone who could speak up for you? Is there someone who could speak up to this psychiatrist?' I enquired. Peter determined that his mother could do it and would probably be willing to do so. We invited his mother in and shared what we had discussed: Peter's preference for 'unique person' and his distress when the psychiatrist repeatedly used the term Asperger's. We asked if his mother could speak up for him about this, to which his mother agreed. Peter came to the next session ready to talk.

This work proved incredibly helpful over the years of working with Peter as he returned to high school and found the need for supports and services in school. He was able to accept them, and his mother was able to speak up for him and help build a community of support for him. Later, Peter went on to community college and then university and faced several quite serious challenges but with help he was able to navigate these systems and accepted the supports provided to him for his Asperger's.

## *Building awareness through experience-near descriptions*

In order to stay close to experience-near descriptions of autism, I ask questions about common challenges, concerns and characteristics associated with autism. As part of this inquiry, I seek to understand the person's unique sensory and social profiles (Paradiz, 2009), as well as their skills and challenges. I see each of my questions as an entry point to further inquiry to more fully render their experience. The information that I gather helps us in co-creating an alternative story to the problem, a preferred identity and preferred action.

### **Sensory profile**

I start by asking if they know the five senses (visual, gustatory, tactile, auditory, olfactory). Children are often excited to share their knowledge (e.g. see, taste, touch, hear, smell). Adults are typically curious as to why I am asking. First, I explain that I have come to understand that everyone has unique sensory processing and that we do not often pay attention to this, but that I have learnt that the way we process sensory stimuli can affect how we learn, how we relate to others, and how

we experience our bodies and environment. I then ask a broad question about whether they or their family members have ever noticed any sensory processing differences, sensitivities or interests. Sometimes, this question yields some information, but often I need to get more specific with my questions, asking one by one about each sense. I also share three additional sensory systems that I am aware of: proprioceptive (body awareness), vestibular (body movement) (Paradiz, 2009) and interoceptive (recognition of internal cues) and ask about these as well.

For each sense, I ask about sensitivities (stimulus that are bothersome, overwhelming or painful), acuities (senses they think are really well developed and easily pick up stimulus but might not be experienced as problematic), and seeking (stimulus that are pleasing, calming, that they seek out or seem to need). I also attend to indications that a person is not registering a certain stimulus. When needed, I give examples of some things I hear from others and ask if any of those stand out to them (e.g. 'with bothersome noises, sometimes I hear about fire alarms, sirens, blenders, vacuums, toilets flushing, dryers, babies crying, whining, dogs barking' or 'with acuities, I sometimes hear about music ability, really good hearing or picking up on noises others don't seem to hear'). I often share that I am not looking for a particular answer and that affirming any of these does not mean there is anything wrong, but rather gives me information about how they are taking in information. I also use quite a bit of transparency around my own sensory profile and make a point to ask everyone in the room about their sensory processing to highlight everyone's uniqueness and support a more expansive understanding of the different ways each person perceives the world.

### **Social profile**

Entry points to understanding a person's social profile include enquiring about:

- Who is viewed as family?
- Who is viewed as a friend?
- What is their understanding of 'friend'?
- Who supports them?
- What conditions support them to be comfortable around others (e.g. number of people, environment, activity, familiarity, etc.)?
- What conditions support them to make friends or connect with others (e.g. age, place, interest, etc.)?

- Do their focused interests support connection with others? Do they ever get in the way of connection?
- Do they have interest in a romantic relationship or partnership with another person? Have they ever had this type of relationship? What do they think about or know about these types of relationships?

### **Skills and challenges**

Discussion about skills and challenges is often helpful in the deconstructing some of the strong ideas that exist around weakness, internal flaws or even disability. I have engaged in discussion about skills and challenges with individual clients, in family sessions, in school-based trainings for special education teachers and when engaging students in discussion about autism sensitivity and understanding and acceptance of differences.

#### **Define and describe skills**

I usually start by asking those I am speaking with to define the word 'skill'. I tend to hear things like 'something you are good at', 'something that comes easily to you', 'something you know a lot about'. I then ask for those in the room to share some skills they have or have developed. If it is just myself and the client, I will share three of mine and ask them to share three of theirs. Sometimes I will ask questions about skills in particular environments, such as school.

#### **Define and describe challenges**

I then ask what 'challenge means', usually getting a response like 'things that are hard', 'a task you can't do', 'something that you don't like', 'something someone makes you do'. I try to honour some of the frustration or even silliness that comes out if I am in a group. In groups, I ask if a few people would be comfortable sharing challenges they have faced by saying just a word or phrase. If in an individual session, I share three challenges and ask the client to share three. Usually, I can point out that someone mentioned something as a skill while another person mentioned that same thing as a challenge. This highlights that most people have slightly different skills and challenges, but some may be the same. I then share that with most challenges, it is possible to work on them and then they become less challenging or might even become a skill. I offer the idea that some things continue to present a challenge but we might be able to get help from others so they become less challenging. I also engage in transparency

about the challenges I have faced and where I have either worked to build skills or been able to get support.

After listing the skills and challenges we each face, we explore how we want to talk about them or if there are certain names or labels that others might use. Like with Peter, I often identify the combinations of skills and challenges that are identified in clinical terms as autism. This opens up discussion about their understandings and preferences in relation to this label.

## Navigating systems through advocacy and communities of support

Explorations of sensory profiles, social profiles and skills and challenges are ways to elicit the knowledges and skills that clients hold about what is helpful for them. The information yielded from these explorations serves as the basis for promoting the client's agency and action. Self-advocacy is the act of representing one's self, one's view and one's interests (Lexico, 2021). This requires some awareness, ability to know what is needed or wanted, and ability to communicate this in some way. It is also important that there is an understanding of how to advocate in a way that gets a response the person is hoping for and avoids making a problem worse, while understanding something about navigating the system in which these needs can be met.<sup>2</sup> I often ask, 'What leads to the problem getting bigger and what leads to the problem getting smaller or staying the same size?' (adapted from Beaudoin, 2014). When gathering this information, we are thickening the story of a person's experiences, skills and knowledges in relation to organising and regulating one's physiology, what educational and behavioural approaches might call regulation or calming strategies, which may be accessed by the person alone (self-regulation) or with support from others (co-regulation).

### What does self-advocacy look like?

Self-advocacy starts with simple expressions such as:

- saying no
- asking for help
- expressing confusion or lack of understanding
- expressing interests
- expressing preferences
- expressing dislikes, discomfort or distress.

Our sessions become a space to support, practice and celebrate these forms of self-advocacy. I often find that the individuals I work with benefit from hearing from others that it is okay to advocate for themselves in this way. They also need to experience others listening. I am often met with responses such as 'it doesn't matter, it won't help anyway' because they have had previous experiences of their attempts to advocate for themselves being dismissed, overlooked or even shamed. I sometimes write out on paper or a whiteboard reminders of ways to self-advocate and leave this out during sessions. Sometimes, I contrive situations in which the person will have an opportunity to speak up. At other times, I notice their discontent and simply point to the page as a cue or offer the page for them to point to, especially with individuals for whom expressive language is not as well developed or easily accessed. In telehealth settings, this can be done by sharing a document on screen or using the chat function.

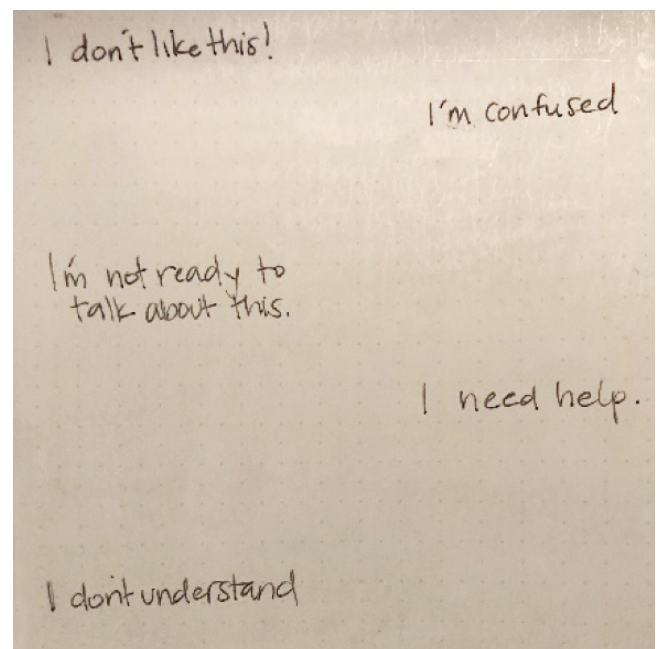


Figure 1: Self-advocacy prompts

*When working with a 12-year-old boy, I showed a video in which a boy was crying. I was hoping to explore some of the social messages about boys and men crying as this video presented an alternative to what I had heard my client say about it not being okay for boys to cry. When the boy in the video began to cry, I noticed my client with his head down, hoodie over his head with drawstrings pulled closed. I paused the video, presented the written self-advocacy cues we had previously discussed and noted that I could see something was wrong. He looked at the page, and said*

*'I don't like this'. I acknowledged his discomfort and said we could stop it for the day but that we might come back to it again next session. I asked what would be helpful to address the discomfort, to which he asked if he could go get a drink of water. I happily allowed him this break from the session and from me, and when he returned, we explored the effects of expressing his dislike and his subsequent request for a drink. The following session, we began with a review of ways he had learnt to deal with the presence of discomfort and then tried the video again. This time, he watched the entire video and, afterward, discussed it with me.*

*In order to support a 10-year-old to express his confusion, I contrived a situation. First, we discussed how everyone is confused sometimes, and that it is okay to let others know if you do not understand or are confused. This had come up in several settings and I had observed the client getting into difficult situations because of confusion. In this session, I presented visuals with words as we created a list of what he had seen others do when they did not understand something (e.g. ask for help, say they don't understand, try to find out by looking on the internet). I then told him that I was going to say something that was quite confusing, and he could choose how he wanted to speak up about this. I said, 'In San Diego, there is a lot of precipitation and therefore people's hair often gets frizzy'. The first two times, I said this, he did not choose a way to speak up about being confused, even though the visual was next to him, in his view. Instead, he said he understood what I was saying, although each time, when asked, his explanation was not connected to what I said. For example, on one occasion, he said something about homeless people being in San Diego – likely because there was a homeless encampment visible from my office window at the time. Prior to each time that I repeated the phrase, I provided him with a clear verbal reminder that it would be confusing and that I wanted him to practice telling me he did not understand by choosing one of the phrases on the visual. The third time I said the phrase, he pointed to 'I don't understand'. I acknowledged what he pointed to as a communication and expressed that it was helpful to know that he did not understand. I highlighted that it was, in fact, quite confusing and then explained it to him in a way he could better understand as a means to provide an experience in which he benefited from greater clarity following his self-advocacy. We then explored what it was like to recognise and say that he did not understand. I also engaged him to express what he liked and did not like about this. In future sessions, he was quicker to let me know when he was confused, using similar visual prompts.*

I see this initial focus on self-advocacy as important for creating an environment in which there can be a respectful exchange of ideas, verbal or not. It is important to me that the people I work with know that they can speak up with me and that I will listen. My hope is that this will then support further therapeutic relating and serve as a catalyst to future self-advocacy across settings.

As with any skill, there are many nuances and intricacies that can make such advocacy quite complex. Self-advocacy can become more advanced and nuanced depending on age, environment and comfort. Typically, I work with clients to explore the following:

- understanding that everyone has skills and challenges
- understanding, recognising and acknowledging their own skills and challenges and others' skills and challenges
- allowing them to name their challenges
- understanding that support people may call their challenges a particular word or term in order to provide services and supports
- understanding it is okay to speak up, get help, and acknowledge a challenge or discomfort
- knowing what will help and developing skills to address own challenges (self and co-regulation)
- understanding safe people, disclosure (partial or full) and communities of support
- developing a plan
- practicing speaking up or inviting others to be part of a community of support
- noticing and celebrating attempts at self-advocacy.

There are times, however, when advocating for oneself is an unfair demand. When a person is overloaded with stimuli or distressed in any way, it may be harder to organise their system (which may require co-regulation) to locate and use language to express an awareness of what is needed (input, processing and output<sup>3</sup>). Self-advocacy is something to strive for, but likely best accessed when the body and brain are at least somewhat regulated. A request that an ally advocate on one's behalf, such as in Peter's case, may be helpful at other times. And at times, collective advocacy is more powerful or necessary given the system. It is also important to note that expectations of self-advocacy can be informed by ableist ideas that contribute to these unfair demands.<sup>4</sup>

I often spend a great deal of time engaging clients in considering what supports their experience of regulation, including the ways they can attend to regulation and the ways that others, such as myself, can support their regulation. As part of this discussion and ultimately their action plan, we will also discuss the concepts of full and partial disclosure (Paradiz, 2009), that is when, with whom and what information may be necessary and helpful to share with others. With this, we will explore allies and creating communities of support because, unfortunately, not all people will be supportive and understanding. It has also been my experience in clinical, educational and family settings that not all adults are in a space to listen and respond in a supportive manner, and some systems are not set up to honour the needs of those with learning, behavioural or cognitive differences, particularly when there are intersections with other marginalised identities or appearances. No matter what the situation, but especially in these cases, it has been important to create a community of support. Communities of support for autistic individuals have often consisted of support staff, parents, siblings and peer allies.

Mario was a 12-year-old boy I had been working with for a few months. He had diagnosis of Asperger's, which he had known about for some time but did not quite understand. In one of his classes, a teacher had announced to the class that Mario had Asperger's. He reported this to me in a session with some pride, but then told me about some of the ways that others were picking on him. Mario did not always know that he was being picked on, singled out or excluded. Sometimes this shielded him from pain, but at other times he was aware that others were treating him poorly and it hurt to not understand why. His and his mother's story of the school he was at did not give the impression that many of the adults understood him either, and some of the adults were even complicit to the poor treatment he was experiencing.

I had spent several months with Mario exploring the Asperger's label, his sensory and social profile, and his skills and challenges. We had developed a running document with pictures of what he understood about Asperger's and some of his and other's quotes about his experience of Asperger's, a label he said he liked. It seemed like a good time to start working on developing a community of support. Mario liked this idea. He even told me about a club he had attempted to form to keep bullies away. Unfortunately, this club did not last because the boys he had asked to join the club 'ended up being mean'. We explored whether a club was what he wanted and he stated that he was

becoming a bit too old for clubs. He suggested that it could help if he had confidence that others knew the same things he knew about Asperger's. We explored different ideas for sharing his knowledge and landed on writing a letter. Mario asked me to pen the letter because handwriting was hard for him. He then asked that the letter be written as if it were from me. I was hesitant at first, hoping this letter could centre his voice, but he felt strongly that adults would want it to come from a doctor. We compromised on co-signing the letter and including his own quotes. The contents of the letter were determined through me interviewing Mario about the various points discussed in this paper, drawing on the understandings and philosophical foundations explored in Parts 1 and 2 of this series of papers. This scaffolded a co-created rendering of his preferred identity in the letter. Once the letter was completed, we invited Mario's mother in to help identify members of his family, peers at school and in his neighbourhood, and other adults who could be supportive of Mario and this understanding of his Asperger's. This took some time because Mario initially wanted to share the letter with everyone. However, after further questioning and help from his mother, we were able to identify that some of the people originally named might not understand what Mario was sharing and may not support him in the ways he was hoping for. Below is the letter that the potential allies received. We hoped that they might bear witness to Mario's preferred identity, honour his knowledge and act as a community of support.

1/24/13

To People in \_\_\_\_\_ Life,

\_\_\_\_\_ wants to share some ideas he has that he hopes will help others to think about him the way he wants - in a good way ☺

\_\_\_\_\_ wants people to know that he has Aspergers so others can know that "I'm not doing things to make others uncomfortable but sometimes don't realize the things I do that others don't like" He is hopeful that others can understand this to help him rather than getting upset or thinking badly.

\_\_\_\_\_ likes Aspergers because

- "I have good memory"
- "It makes me different and I like being different"

\_\_\_\_\_ wants others to know that he thinks differently but can still get the same answers as others for example, he may use his brain differently to solve a math problem and "that's ok". He likes that he solves problems differently. He also wants others to know he has a different sense of humor which he also likes.

Sometimes Aspergers might be useful to \_\_\_\_\_ because he can really focus. \_\_\_\_\_ also thinks that because of Aspergers he has a different imagination.

\_\_\_\_\_ wants others to know about Aspergers. He states

- "I have different social skills sometimes. Its hard for me to make or keep friends"
- "Sometimes I say things differently and talk faster than I should"
- "I learn differently. I may not learn like you I focus on certain details and I use those details to memorize things"
- "Sometimes I get nervous and it helps me stay focused helps me not worry and helps me stay calm"
- "Sometimes I take things seriously and may not understand a joke"

I hope others will understand me better if they know these things about me and then I can develop more friendships and better relationships. Thank you for reading and considering what \_\_\_\_\_ hopes others will learn about him.

Figure 2. Letter to Mario's potential allies



## Pulling it all together

In this third part of the three-part series on narrative practices and autism, I have presented considerations about the effects of diagnostic categories on constructions of identity, and have offered ways to explore diagnostic terminology and labelling as just one conceptualisation while acknowledging the limitations and pathologising that exist. I have also offered ways to support clients to navigate systems in which a DSM diagnosis is required, while not affording the DSM power over the construction of a person's identity. As part of a process of supporting the development of a preferred identity, I have described steps to engage clients in conversations about their sensory profile, social profile, skills and challenges. In order to support further expression of preferences, we explore communities of support while also attending to the challenges that exist for a person. This leads to discussions about navigating systems of support and concepts of advocacy (self and collective), which includes regulation (self-regulation and co-regulation) and communication.

Part 1 and Part 2 are intended to lay some groundwork for therapists and other support persons to join their clients in explorations of identity that are meaningful and free from constraints imposed by normative notions that can inform therapeutic work with autistic individuals and other neurodivergent individuals. I hope that the stories and examples shared throughout all three parts offer a useful scaffolding of practice, and prompt other creative and thoughtful therapeutic engagements with people who experience challenges or differences like those described in these papers.

## Notes

- 1 There is some debate about the use of person-first language (individual with autism) versus identity-first language (autistic individual). Many autism self-advocates and those active in the neurodiversity movement advocate for identity-first language. I have chosen to mostly use identity-first language, except in cases in which a person had expressed a preference for person-first language (see Part 1).
- 2 I want to acknowledge that this depiction of self-advocacy may be too simplistic for some, particularly if there are spoken language challenges or other expectations of the system that are imposed on the person in the position of needing to advocate. This relates to the Part 1 discussion of ableism and how this can be a barrier to access.
- 3 For a more detailed discussion on input, processing and output, see Part 1.
- 4 Part 1 discusses how ableism contributes to making therapy inaccessible to some autistic individuals and to others with communication, focus and processing differences and challenges. Although it is beyond the scope of this paper or series, it is important that systems of support take time to consider the ways that ableism informs expectations that are placed on individuals when seeking such support (e.g. a dysregulated person may be expected to calmly express and ask for what they are needing, or a person with visual processing challenges may be expected to accurately complete reams of paperwork in small print with overwhelming amounts of text on each page).

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